STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/16/11 Facility Number: 004268 Provider Number: 155735 AIM Number: 200504460 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Ashford Place Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident sleeping rooms. The facility has a capacity of 68 and had a census of	K0000	Ashford Place Health Campus submits this plan of correction in response to the allegation of noncompliance cited during the Life Safety Code Recertification and State Licensure Survey conducted on May 16, 2011.Please accept this plan of correction as the provider's letter of credible allegation of compliance effective June 15, 2011.The Provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	52 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/19/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0017 SS=E	Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 open use areas were separated from the corridor or met an Exception. LSC 18.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers.	K0017	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.After review, there were no residents found to be affected by alleged deficiency.2. How other residents have the potential to be affected by the same deficient practice will be indentified and what corrective action(s) will be taken.There were no residents with the potential to be affected by the alleged deficiency. 3. What measures will be put into place or what systemic changes wil be made to ensure that the deficient practice does not recur.The fire protection vendor was contacted following the inspection. A smoke	05/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 3 residents observed lounging by the front Reception office as well as any visitor or staff using the front entrance to evacuate the facility. Findings include: Based on observation on 05/16/11 at 12:44 p.m. with the Maintenance Supervisor, the sliding glass doors installed at the front Reception office were not self closing and were open to the front entrance corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 18.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 05/16/11 at 12:47 p.m. with the Maintenance Supervisor, it was acknowledged the front Reception office was open to the entry corridor without supervision from the nurse's station and was not protected by automatic smoke		detector was installed in the business office above the glass sliding window on 5-25-11. See exhibit A4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The fire protection vendor will do a bi-annual smoke detector inspection. These inspections/tests will be submitted to our Safety/QA report by plant operations, as completed for monitoring purposes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	detection. 3.1-19(b)			
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on record review and interview, the facility failed to ensure 47 of 47 dampers in the ventilating system's ductwork were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, maintenance requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents including visitors and staff. Findings include: Based on Fire Safety record review on 05/16/11 at 2:45 p.m. with the	K0067	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.After review, there were no residents found to be affected by alleged deficiency.2. How other residents having the potential to be affected by the same deficient practice will be indentified and what corrective action(s) will be taken.All residents have the potential to be affected by the same alleged deficiency.3.. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Plant operations will inspect and provide necessary maintenance to dampers in the ventilating ductwork. Each damper will be logged on the Fire/Smoke Damper Maintenance Record form. See exhibit B4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Plant operations will provide necessary inspection	06/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 01 B. WING	05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	2200 NORTH RILEY HIGHWAY SHELBYVILLE, IN46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Supervisor, documentation was not available to indicate the dampers had ever been inspected. Based on an interview on 05/16/11 at 2:47 p.m. with the Maintenance Supervisor, it was acknowledged the facility does not have any documentation to verify the forty seven fire dampers have ever had a four year maintenance inspection. 3.1-19(b)		and maintenance of dampers every four (4) years as required. Inspections will be submitted to Safety/QA report as completed for monitoring purposes.	